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PRINTED: 12/04/2007 FORM APPROVED OMB NO. 0898-0391

DEPART	MENT OF HEALT	TH AND HUMAN SERVICES		15-1	OMB NO.	
CENTER	S FOR MEDICAL OF DEFICIENCIES CORRECTION	RE & MIFDICAID SERVICES (X1) PROVIDER/SUPPLIEN/CLIA IDENTIFICATION NUMBER	DOZ) MUL	TIPLE CONSTRUCTION NG	(XS) DATE SURVEY COMPLETED	
		096123	B. WING		11/2:1	/2007
NAME OF P	OVIDER OR SUPPLIE		s	TREET ADDRESS, CITY, STATE, ZIP CODE 431 53RD STREET, SE		
101		· _		WASHINGTON, DC 20019	· · · · · · · · · · · · · · · · · · ·	
(X4) ID PREFIX TAG		STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC (DENTIPYING INFORMATION)	JD PREFEX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION ST (EACH CORRECTIVE ACTION ST CROSS-REPERENCED TO THE AP DEFICIENCY)		COMPLETION DATE
W 000	INITIAL COMME	ENTS	W 00	00	·	
W 124	November 19, 2 A random samp from a residential mental retardation survey findings in group home and and a review of incident reports. 483,420(a)(2) P RIGHTS The facility mus Therefore the facility mus Therefore the facility mus Therefore the facility mus Therefore the facility mus The facility mus Therefore the facility mus Therefore the facility mus The strength and treatment, and This STANDAF Basad on obse review, the facil each client to be condition, deve attendant risks refuse treatme #1) included in The findings in 1, Observation administration at 6:29 PM rev medications in Risperdal. Infe	t ensure the rights of all clients. acility must inform each client, ent is a minor), or legal guardian, edical condition, developmental status, attendant risks of of the right to refuse treatment. (D) is not met as evidenced by rvation, interview and record lity failed to ensure the rights of the informed of the client's medical dopmental and behavioral status, of treatment, and the right to int, for one of the four clients (Client the sample, clied: n of the evening medication on November 19, 2007, beginning eated Client #1 received cluding Clonazepam and erview with the nurse during the		This Standard will as evidenced by: a amer will review as use of medication habilitative service chent #1's brother consent. This Standard will review as use of medicated brother and complete incomparation obtained for the aif needed.	nd discusss s and es with er. Informed inate	
L AND COLOR	medication ad	ministration revealed the ROVIDENSUPPLIER REPRESENTATIVES S	SNATURE	ше		(X6) DATE
LABUKAI	mum Po	m		DRS		12.14.0

Any deficiency statement ending with an asteriak (*) denotes a deficiency which the institution may be excussed from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructional). Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correctionits provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility) if deficiencies are clied, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-98) Provious Versions Obsolete

Event ID: GWDXI1

Facility ID: 09/3123

If continuation street Page 1 of 21

PRINTED: 12/04/2007

FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB <u>NO, 0938-0391</u> CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY DOWN MULTIPLE CONSTRUCTION (X1) PROMDER/SUPPLIER/CLIA IDENTIFICATION NUMBER STATEMENT OF DEFICIENCIES COMPLETED ND FLAN OF CORRECTION A. BUILDING ... B! WING 11/2:1/2007 69G123 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 431 SERD STREET, SE Washington. DC 20019 IDI PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION SUMMARY STATEMENT OF DEFICIENCE (XA) 1D PREFIX PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE REGULATORY OR LSC IDENTIFYING INFORMATION) DEFICIENCY TAG W 124 Continued From page 1 W 124 aforementioned medications were used to a amer will obtain informed consent prior to use of and/or participation address the client's behavior management. Interview with the Qualified Mental Retardation Professional (QMRP) on November 19, 2007 at 6:38 PM was conducted to ascertain information in treatment. 1.5.0% about Client #2's ability to give informed consent a ameo will also review ongoing for the use of medications and habilitation and discuss risks/ benifits of treatment. services. According to the QMRP, Client #1 was not capable of giving informed consent for the use of her medications and habilitation services. The interview was verified by the client's a Document will remain Psychological Evaluation (dated September 29, on file for neview. 2007) on November 21, 2007 at 11:57 AM that documented Client #1 did "not evidence the capacity to make decisions on her behalf regarding her habilitation planning, placement, treatment, financial, and medical matters." The 1-5-08 (2) Omer will review and Psychological Evaluation further documented that ongoing discurs with the medical the client "could not execute a durable power of ream, request verifiertion Additionally, interview with the QMRP revealed that Client #1 had once document dolained family involvement (brother) but did notinave a it will be filed into chent #1's record for legal guardian. Further interview with the QMRP: and review of the client's records failed to provide documented evidence that informed consent was obtained for the use of the client's psychotropic medication. At the time of the survey, the facility falled to provide evidence that Client #1's review. In huture, Omer/Nume? will request copies of all documents prior to procedures. treatment needs, including the benefits and potential side effects associated with the medications, and the right to refuse treatment. had been explained to her and/or a legally authorized representative. 2. Review of Client #1's medical record on November 21, 2007 at 7:52 PM revealed that the If continuation sheet Page 2 of 21

FORM CMS-2557(02-99) Previous Versions Obsalate

Even ID: GWZX11

Facility (D: 09B125

DEPART	MENT OF HEALTH	I AND HUMAN SERVICES		·	PRINTED: 12/04/2007 FORM APPROVED OMB NO. 0938-0391
STATEMENT	S FOR MEDICARE OF DEFICIENCIES CORRECTION	& MEDICALD SERVICES (X1) PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:	DEZ) MULTI A. BUILDIN	PLE CONSTRUCTION	COMPLETED
		095123	B. WING_		11/2:1/2007
NAME OF P	ROVIDER OR SUPPLIER			reet address, city, state, zip co 31 53RD STREET, se	DE
IDI		-		Vashington, DC 20019	
(X4) ID PREFIX TAG	/요시아나 다른얼(그)도시(^	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LEC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S FLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLETION
W 124	Urologist recomme a Cystoscopy. Fur record revealed th on August 8, 2007	en by the Unologist. The ended to schedule the client for the review of the medical at a Cystoscopy was completed	W 124		
W 130	Interview with the QMRP on November 21, 2007 revealed that Client #1's brother signed a consent at the hospital, however, there was no documented evidence of the consent for Client #1's Cystoscopy. At the time of the survey, the facility failed to provide evidence that Client #1's treatment needs, and the right to refuse treatment, had been explained to her and/or a legally authorized representative. 483.420(a)(7) PROTECTION OF CLIENTS		W 130	M130	
- -	Therefore, the factored treatment and car This STANDARD Based on observations of the control of	ensure the rights of all clients. Why must ensure privacy during e of personal needs. Is not met as evidented by: alion and interview, the facility ach client's right to privacy, for lients (Clients #1, #2 #3 and #4).	-	This Standard in met as eviden	
	administration on revealed Client #3 medications. Who Clients #1, #3, an Additionally, one also present while	the evening medication November 19, 2007 at 7:47 PNI in her bedroom receiving her de receiving her medications, d #8 were also in heribedroom, staff and two surveyors were e Client #2's medication was d. The facility's nurse was	-	RN will provide training for N stabl on adher privacy during treatments in the stable of the stable	additional urang 12.23.07 urang to ongoing on medical ents.
FORM CMS-2	2587(02-99) Previous Versio	ins Obsolete Event 10: GWEX	ז דר	acility ID: 09G123	If continuation short Page 3 of 21

		I AND HUMAN SERVICES & MEDICAID SERVICES	,		FORM A	12/04/2007 APPROVED 0938-0391
TATEMENT	OF DEMCIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(XZ) MULTI (A. BUILDIN	PLE CONSTRUCTION	(003) DATE SU COMPLET	RVEY (ED
·		09G123	B. WING _		11/2:1	/2007
NAME OF P	ROYDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE 31 53RD STREET, SE		
ID1			1 -	vashington, DC 20019		
(X4) ID PREFIX TAG	(FACH DEFICIENC)	Jement of Deficiencies (Must be preceded by Full SC (Dentifying Information)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	ULD BE	(XE) COMPLETION DATE
W 130	Client # 2's scalp a was applied to her that the client's bed during the observated administration. The receive her oral machanictal (prescribe the survey, the faci	ige 3 Friamcinolone Acetorlide to and Lubrifresh PM cintment left eye. It should be noted broom door was wide topened from of the medication e client also was observed to client also was observed to dications; Keppra and dir seizures). At the time of lity felled to maintain Client while receiving her	W 130	W130, continued RN Will conduct routive observations to further compliance with this servations. (2) Reference nes to W130 #1.		
W 148	administration on a revealed Client #3 medications. While Clients #1, #2 and Additionally, one stales present while being administered receive all of her or Ascorbic Acid, Car Keppra, Lactulose the survey, the facility reclications. 483.420(c)(6) COM CLIENTS, PAREM The facility must reparents or guardial changes in the clied limited to, serious in unauthorized above.	otify promptly the client's n of any significant incidents, or nt's condition including, but not liness, accident, death, abuse, sence	W 148	W148 This Standard well		12:31:07 ongang
	Based on interview	is not met as evidented by: y and record review, the facility e client's legal guardian and/or				

	•	AND HUMAN SERVICES			_	FORM.	12/04/2007 APPROVED 0938-0391
TATEMEN	l'of desidences De Correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	0<2) k		TIPLE CONSTRUCTION CC	OMPLE	RVEY
		093123	s. Wi	NG_		11/2	1/2007
NAME OF F	ROVIDER OR SUPPLIER		- 	4	REET ADDRESS, CITY, STATE, ZIP CODE 131 53RD STREET, SE NASHINGTON, DC 20019		
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W 148	family member was injury of unknown or clients (Client #7) the finding include Review of the Incide on November 20, 20 revealed that on Authat while at the day observed to have a #7 was taken to the subsequently diagnetiow. Further reviewed that the climotified of the incide (twenty-three days at the Qualified Mental (CMRP) on November evealed information incident manageme CMRP, the guardian injuries of unknown survey, the facility faguardian was made incident in a timely fast 483,420(d)(1) STAF CLIENTS	promptly made aware of an rigin, for one of the eight rain resided in the fadility. s: ent reports and investigations 207 beginning at 2:01 PM gust 22, 2007, staff reported or program Client #7 was swellen right elbown Client emergency room and was exert on September 14, 2007 after the injury). Interview with a Retardation Professional car 20, 2007, at 12:06 PM or regarding the facility's ent system. According to the congin. At the time of the siled to ensure Client #7's sware of the aforementioned namer. F TREATMENT OF	W 1			otron nent and arise	12:31:07
·	Based on interview : failed to establish at	o not met as evidenced by: and record review, the facility rd/or implement policies that health and safety, for three of					
RM CMS-25	67(02-99) Previous Versions	Chapteta Event 10: GWZ\$11		Pac	ally ID: 09G123 If continued	tion sheet	Page 5 of 21

		(AND HUMAN SERVICES & MEDICAID SERVICES			PRINTED: 12 FORM AP OMB NO. 08	PROVED
STATEMENT	OF DEFICIENCIES OF CORRECTION	O(1) PROVIDENSUPPLIENCLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BIJILDIN	PLE CONSTRUCTION	(AS) DATE SURV COMPLETE	
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W 149	the eight clients (Cresided in the facility resided in the facility. The findings included the findings included in the facility failed of incidents as documentary policy. The facility of the incident of the follow abuse and/or injurity not reported as requested the facility abuse and/or injurity not reported as requested the facility was taken to the subsequently diagred bow. Further revealed that the acceptance in the facility of the facili	lients #1, #2, and #7) that ity. e: d to ensure the firmely reporting unnented in its "Incident ity. ent reports and investigations 1007 beginning at 2:01 PM ing incidents (allegations of es of unknown source) were	W 149	Reference response WI4B. Incident Investigation complete ail reported incidents	trons d for s,	
	were notified of the 2007. b. On September 9 Client #1 was obsewrist. According to administrator was 1 September 9, 2007 however, the Quaff Professional (QMR on the Incident repays econd blister on noted that there was immediately notified injuries. It should be a second blister or noted that there was immediately notified injuries.	incident on September 14, 2007, staff reported that rived with a blister on her left to the Incident report, the notified of the incident on 7. On September 10,:2007, fied Mental Retardation or that revealed Client #1 had her right wrist. It should be as no evidence the DDH was do fine aforementioned be additionally noted that there had the administrator had been		amerwill immediate initiate investigation of file information within the designated time appropriate discussion will be appropriate for failure to an to policy.	plines plinary oned there	
-1084 /384C A4	MY (CO. CO) Electrica Vandam	c Obsolete Stept 151: GWZZ1	7 . Fa	dily i0: 096129 If conf	inusion sheet Pr	ad≘ 6 of 21

AND PLAN OF CORRECTION OPERIOR (X1) PROVIDER SUPPLIER (X2) MULTIPLE CONSTRUCTION DENTIFICATION NUMBER: A BUILDING L WING NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CNY, STATE, ZIP CODE			AND HUMAN SERVICES & MEDICAID SERVICES					FORM A	12/64/2007 PPROVED
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made aware of the bilister on Client #1's right whist documented via addendum on September 10, 2007. Review of incidents during pre-survey extinities revealed staff reported that on July 23, 2007. Client #7 sustained a skin tear on her right elbow with some swelling noted. During the survey process, there was neither any evidence of an incident report for the aforementioned incident mor any evidence that the administrator was made aware of the incident. Additionally, the POH was not made aware of the incident until September 14, 2007. Interview with the CMRP on November 20, 2007, at 12:08 PM revealed information regarding the facility's incident menagement system. According to the CMRP, the administrator and the Department of Health where to be notified immediately of all allegations of abuse and injuries of unknown origin. It should be further noted that the CMRP-revealed that immediate notifications were also to made to each tilest's next of kin and/or legal guardian. Neviety of the facility "incident Management" policy on November 20, 2007, revealed that serious reported to the Department of Health (DDH) followed by written notification was to be strade to the offerts involved family members of sustediates At the time of the survey, the facility risked to ensure timely notification was to be strade to the offerts involved family members of sustediates At the time of the survey, the facility risked to ensure timely notification was to be strade to assure timely notification was to be strade to the offerts involved family members of sustediates and the survey, the facility risked to ensure timely notification was to be strade to assure timely notification was to be assured to the offerts involved family members of sustediates and the survey. The facility risked to ensure timely notification was to be a trade to assure timely notification was to be assured to the offerts	化马克丹马	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREF	×	PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE		TE C	(XS) DATE
revealed staff reported that on July 23, 2007. Client #7 subtained a skin tear on her right elbow with some swelling noted. During the survey process, there was neither any evidence of an incident report for the aforementioned fictident nor any evidence that the administrator was made aware of the incident. Additionally, the POH was not made aware of the incident until September 14, 2007. Interview with the QMRP on November 20, 2907, at 12:00 PM revealed information regarding the facility's incident menagement system. According to the QMRP, the administrator and the Department of Health were to be notified immediately of all allegations of abuse and injuries of unknown origin. It should be further noted that the QMRP revealed that immediate modifications were also to made to each idlesting next of kin and/or legal guardian. Review of the facility "incident Management" policy on November 20, 2007, revealed that serious reportable incidents must be immediately verbally reported to the Department of Health (DDH) followed by written notification within twenty-four hours. Additionally, the policy documented that Immediate verbal notification was to be hade to the client's involved tarrilly members or guardians. At the time of the survey, the facility failed to ensure timely notifications as required by their "incident Management" policy. 2. The facility failed to ensure investigations were conducted as specified in their "incident" messagement.	W 149	made aware of the b documented via add	hister on Client#1's right wrist	W 1			ula a T	-	`
at 12:06 PM revealed information regarding the facility's Incident management system. According to the QMRP, the administrator and the Department of Health were to be notified immediately of all allegations of abuse and injuries of unknown origin. It should be fluther noted that the QMRP revealed that immediate notifications were also to made to each client's next of kin and/or legal guardian. Review of the facility "Incident Management" policy an November 20, 2007, revealed that serious reportable incidents must be immediately verbally followed by written notification within twenty-four hours. Additionally, the pelicy documented that immediate verbal notification was to be made to the client's involved family members or guardians. At the time of the survey, the facility failed to ensure investigations were conducted as specified in their "moident".		revealed staff reports Client #7 sustained a with some swelling n process, there was n incident report for the nor any evidence tha aware of the incident not made aware of the	ad that on July 23, 2007, a skin tear on her fight elbow oted. During the survey either any evidence of an a aforementioned litcident If the administrator was made Additionally, the BOH was			all notifications	are	- [-	508
conducted as specified in their "Incident		at 12:06 PM revealed acility's incident man to the QMRP, the admostration the QMRP, the admostration of Health minediately of all alles of the QMRP; total the QMRP; total that the QMRP; total that the QMRP; total that the QMRP; total to fin and/or legal acility "Incident Man tovember 20, 2007, reportable incidents me ported to the Depart politics. Additionally, the mediate verbal notification of the survinsure timely notification to the time of the survinsure timely notification incident Management incident Management	Information regarding the agement system. Paccording ministrator and the ware to be notified gations of abuse and figin. It should be further revealed that immediate to made to each client's aliguardian. Review of the agement "policy on evested that serious ment of Health (DDH) iffication within twenty-four a policy documented that ication was to be made to mily members or quardians; ey, the facility failed to one se required by their "policy."			amer will provide staff training on i reporting policy procedures,	additi nadent and	oral	
CMS-2567(02-66) Previous Versions Obsolete E-Writ ID; GWZVI11 Facility ID; 05-6123 If continuation sheet Page 7 of 21	2, co	The facility falled to a number of the facility falled to a specified to a specif	ensure investigations were I in their "Incidenti	-		Milen is, operation, frame in the second of the second			. <u>.</u>
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name of P	ROVIDER OR SUPPLIER			4:	eet address, city, state, zip code 31 53RD Street, se Fashington, DC 20019		
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W 149	Continued From pa Management" polic	-	W	149			
	on November 20, 2 revealed the following abuse and/or injuris	ent reports and investigations. OD7-beginning at 2:01 PM ing incidents (allegations of es of taknown source) were stigated as required:	:				
·	#7 was observed to fight elbow at the observed to the emerging subsequently diagnous elbow. At the time	007, staff reported that Client in have a swollen lay program. Client #7 was ency room and was losed with a contusion of the of the survey, there was no forementioned incident was					
	Client #2 was obse breakdown on the i thumb". At the tim	2007, staff reported that eved with a "superficial skin neer right hand above her need the survey, thete was not forementioned incident was	;				
•	on November 20, 2 information regardit management syste the facility is require investigations for in Review of the facility policy on Novembe interview with the C serious reportable investigated upon the time of the surv	hat interview with the CMRP D07, at 12:05 PM revealed on the facility's incident on. According to the CMRP, edite immediately initiate juries of unknown schace by s'incident Management' of 20, 2007, verified the incidents were to be notification of the incident. At ey, the facility failed to ensure conducted as specified in agement" policy.					

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	12/04/2007 APPROVED 093 <u>8-0391</u>	
TATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDERSUPPLIERCLIA IDENTIFICATION NUMBER:	(X2) N A. BU	_	PLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY TEC	
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W 149	3. The facility failed results were reporte "Incident Managem Review of the Incident	to ensure that investigation and as specified in their ent" policy. ent reports and investigations	W	149				
	revealed the follow, abuse and/or injurie a. On August 22, 20	007 beginning at 2:01 PM ng incidents (allegations of unknown source): 007, staff reported that Client						
	taken to the emerge	ay program. Client #7 was		•				
	Client #1 was obserwing to administrator was n September 9, 2007. however, the QIVIRI on the incident reposition of the incident repositions.							
	at 12:06 PM revealed facility 's incident in According to the QI immediately initiate unknown source an within five working of "Incident Managem 2007, revealed that reported to the prov	MRP on Nevember 20, 2007, ad information regarding the paragement system. ARP, the facility is required to an investigation for injuries of a complete the investigation lays. Review of the facility's ent" policy on November 20, all investigations were to be ider's incident Management our days for review and						

ORM CMS-2567(02-96) Previous Versions Obsolets

Ebent to: GWZ\$11

Facility ID: 086123

If continuation sheet Page 9 of 21

		I AND HUMAN SERVICES E & MEDICAID SERVICES			F	ORM.	12/04/2007 APPROVED 0938-0391
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	· · · · · · · · · · · · · · · · · · ·	096123	g. Wil	1Ġ_		11/21	/2007
NAME OF F	PROVIDER OR SUPPLIER		•	45	REET ADDRESS. CITY, STATE, ZIP CODE 31 59RD STREET, SE VASHINGTON, DC 28019	<u>3</u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TEMENT OF PERCIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	TE	COMPLETION DATE
W 149	Regulatory Administ Management Unit with the firme of the survit's "Incident Mana implemented as out investigations were specified. 483.420(d)(2) STA	ge 8 That it reaches the Health Stration and MRDDA Incident within five working days." At Yey, the facility falledito ensure gement" policy was tilined making certain that reviewed and forwarded as	W 1		W153		
	mistreatment, negle injuries of unknown immediately to the	sure that all allegations of ect or abuse, as well as source, are reported administrator or to other act with State law infough thes.			This Standard will be met as evidenced by Reference responses to W148 EW149.	e)`'	1.5.08 ongoing
	Based on interview failed to ensure that injuries of unknown immediately to the appropriate officials in accordant Chapter 35 3519.10 procedures, for two #1, and #7) that results investigations on No at 2:01 PM revealed (allegations of abus source) were not re-	cident reports and ovember 20, 2007 beginning I the following incidents e and/or injuries of unknown ported as required:			and will report all incidents to the administrator of other officials in accordance with state law. Routine file/record review will be completed to further ensure complicing with this standard.	te	

1RM CMS-2597(02-98) Previous Versions Obsolute

Event ID: CWZdi 1

Facility 10: 086123

Iffcontinuation sheet Page 10 of 21

PRINTED: 12/04/2007

		'H AND HUMAN SERVICE				FO	ED: 12/04/2007 RM APPROVED
TATEMENT	TO FUR MEDICAR FOF DEFICIENCIES OF CORRECTION	E & MEDICAID SERVICES (M1) PROVIDERSUPPLIERICLE DENTIFICATION NUMBER:	0.62		PLE CONSTRUCTION	(XS) DAT	10.0938-0391 E SURVEY FLETED
	. w/	099123	· - · - - -	VING			1/21/2007
NAME OF P	rovider or supplier			4	eet address, city, stati 31 52RD STREET, SE IASHINGTON, DC 200*	E, ZIP CODE	
(%4) ID PREFIX TAG	(EACH DEFICIENC	CATEMENT OF DESIGNENCIES CYMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PR	EPIX. AG	(EACH CORRECTIVE CROSS-RETERENCED	N OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE HENCY)	(XS) COMPLETION DATE
W 153	taken to the ement subsequently diag elbow, Further re- revealed that both	day program. Client#7 wa gency room and was mosed with a contusion of t view of the incident report the administrator and the alth (DOH) were notified of	as the	/ 153			
	Client #1 was obsidered wrist. According administrator was September 9, 200 however, the Qual Professional (OMion the incident repaired associated that there were the content of the cont	9, 2007, staff reported that erved with a blister on her leto the incident report, the notified of the incident on 7. On September 10, 2007 lifted Mental Retardation RP) documented an addendent that revealed Client #1 in her right wrist. It should be mo evidence the DDH was mentioned injuries.	deum hadi				
	medical record on PM revealed that the Podiatrist on Februari and incovered a "black right great to an addiscoloration was the client to a Dere 2007 at 7:40 PM, a with the nurse to a incident report regincident. According	erview and review of Client November 21, 2007 at 7:33 the client was seen by the wary 26, 2007. Further revialed that the Podiatrist ok discoloration" of the client indicated that if the not healed in one week referationgist. On November an interview was conducted as contain if there was an arding the aforementioned by to the facility's nurse there exidence of an incident	2 6w 4s 21,				
	revealed staff repo	ents during pre-survey action inted that on July 23, 2007, d a skin tear on her right eli	1			·	
RM CMS-26	67(02-99) Previous Version	s Obsolute Event (Dr.	GWZH1+	Faci	lly ID: 09G123	If continuation she	et Page 11 of 21

CENTE	RS FOR MEDICAR TOF DEDICIENCIES	H AND HUMAN SERVICES E & MEDICAID SERVICES (K1) PROVIDERGUPPHERICLIA	(x2) M	JLTIFLE CONSTRUCTION	FRINTED: FORM A OMB NIO. (CS) DATE SUI	\PPROVED 0938-0391
ND PLAN	OF CORRECTION	DENTIFICATION NUMBER	A BUIL		-COMPLET	
		09G12S	a. WN	3	11/21	/2007
NAME OF (ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 431 53RD STREET, SE WASHINGTON, DC 20019		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DÉFICIENCIÉS Y MUST HE PRÉCEDED BY PULL LSC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	COMPLETION DATE
W 153	with some swelling process, there was incident report for hor any evidence to aware of the incide	age 11 noted. During the survey neither any evidence of an the aforementioned incident hat the administratorwas made ant. Additionally, the DOH was the incident until September	Wit	53		
W 154	at 12:06 PM reveal facility's incitient my to the QMRP, the simmediately of all a injuries of unknown survey, the facility to administrator and to notified timely of all injuries of unknown	OMRP on November 20, 2007, led information regarding the arragement system. According administrator was to be notified allegations of abuse and a origin. At the time of the failed to ensure the he Department of Hetalth were regations of abuse and/or a origin as required.	W 1 <i>E</i>	00.0		
	The facility must he violations are thoro	ive evidence that all alleged ughly investigated.		This Standard will met as evidenced	l by:	
	Based on interview failed to ensure all injuries of unknown investigated, for the	e not met as evidenced by: and record review, the facility allegations of abuse and congin were thoroughly ee of the eight clients (Clients resided in the facility.		Reference nesporto W148, & V	í	1.5.08 Ongoing
	at 2:01 PM revealer (allegations of abus			alleged violations a develop purces to prompt reporting	nd nd ensure and	

ORM CMS-2587(02-99) Previous Vestions Obsoleta

Event ID: GWZX11

Facility ID: 09G125

ificontinuation sheet Page 12 of 21

		I AND HUMAN SERVICES			FORM): 12/04/2007 APPROVED
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDERSUPPHERICIA IDENTIFICATION NUMBER	(X2) MUL	TIFLE CONSTRUCTION	(X3) DATE &	
	<u> </u>	09@12\$	B' MING		11/2	21/2007
NAME OF F	PROVIDER OR SUPPLIER		[.	reet address, city, state, zipicode 431 sard street, se Washington, dc 20019		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREFX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JULD BE	(25) COMPLETION DATE
W 154	Continued From pa required:	ge 12	W 154	W154, continued.	· (
	#7 was observed to right elbow, at the d taken to the emerge subsequently diagno elbow. At the time of	ay program. Client#7 was		follow-up.		
-	Client #2 was obser breakdown on the in thumb". At the time	2007, staff reported that ved with a "superficial skin mer right hand above her s of the survey, there was no orementioned incident was				·
	record on November revealed that the clic on February 26, 200 record revealed that "black discoloration" and indicated that if healed in one week Darmatologist. On PM, an interview was ascertain if there was the aforementioned facility's nurse, there evidence of an incide	ew of Client 1's medical r 21, 2807 at 7:32 PM ent was seen by the Pediatrist 7. Further review of the the Podiatrist discovered a of the client's right great toe the discoloration was not refer the client to a November 21, 2007 at 7:40 s conducted with the nurse to san incident report regarding incident. According to the was no documented ent report. Additionally, there is aforementioned incident				
	Mental Retardation F November 20, 2007,	at interview with the Qualified) Professional (QMRP) on at 12:06 PM revealed g the facility's incident				

DRM CMS-2557(02-99) Pravious Versions Obsolete

Even ID: GWZXIII

Facility ID: 08G123

If continuation sheet: Page 13 of 21

PRINTED: 12/04/2007 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICARD SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPMER/CLIA (CO) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION COMPLETED A. BUILDING 09G123 11/21/2007 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 431 53RD STREET, SE IDI WASHINGTON, DC 20019 SUMMARY STATEMENT OF DEFICIENCIES PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REPERENCED TO THE APPROPRIATE (X4) ID ID COMPLETION COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LEC IDENTIFYING INFORMATION) PREFIX TAG PREFIX TAG DEFICIENCY W 154 Confinued From page 13 W 154 management system. According to the OMRP, the facility is required to immediately infiliate investigations for injuries of unknown source. At the time of the survey, the facility failed to ensure that all injuries of unknown origin were investigated. WIS6 483.420(d)(4) STAFF TREATMENT OF W 156 W 156 CLIENTS Reference responses to W148, W149, W153, \$ The results of all investigations must be reported 1.8.08 to the administrator or designated representative ongoing or to other officials in accordance with State law within five working days of the incident. This STANDARD is not met as evidenced by: Based on interview and record review, the facility falled to ensure that the results of all investigations were reported to the administrator or designee within five working days, for two of the eight clients (Clients #1 and #7) residing in the facility. The finding includes: Review of the Incident reports and investigations on November 20, 2007 beginning at 2:01 PM revealed the following incidents (allegations of abuse and/or injuries of unknown source): a. On August 22, 2007, staff reported that Client #7 was observed to have a swollen right elbow at the day program. Client \$7 was taken to the emergency room and was subsequently diagnosed with a contusion of the elbow.

ORM CMS-2557(02-99) Previous Versions Obsolets

b. On September 9, 2007, staff reported that Client #1 was observed with a bilister onther left

Event IE: GWZXH1

Facility ID: 09/01/23

If continuation sheet Page 14 of 21

'ATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION	(X1) PROVIDERSUPPLIERCLIA IDENTIFICATION NUMBER:	i(X2) ML IA. BUIL	iltiple construction Ding	(XS) DATE \$1 COMPLE	
	096121	ia. Wind	3	11/2	1/2007
AME OF PROVIDER OR SUPPLIER D (BTREET ADDRESS, CITY, STATE, ZIP COI 431 EARD STREET, SE WASHINGTON, DC 26619	DE	
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INPORMATION)	id Prefid Tag	PROVIDER'S PLAN OF COR	SHOULD BE	COMPLETION DATE
administrator was no September 9, 2007. Increase on all (OMR) on the Incident report a second bilister on Interview with the Office of Professional (OMR) 12:06 PM revealed facility's incident management of the Office of the Commentation of the Office of the Investigations for all however, failed to padministrator or described of the Invest 483.430(a) QUALIFRETARDATION PRESENTED Client's active integrated, coordinated mental retired.	the incident report; the outified of the incident on outified of the incident on outified of the incident on out that revealed Clant #1 had her right wrist. Light written and the incidents of the incidents of the incidents revide evidence that the incidents revide evidence that the incidents. Light was made aware of the incidents. Light wrist wrist be at the incident was made aware of the incidents. Light wrist wrist be at the incident with the incident was made aware of the incident. Light wrist wrist wrist be at and and monitored by a ardation professional.	. W 1		ll be met	
Based on observation verification, the facionic client's active treatmost and multiple mental Retardation	s not met as evidenced by: on, interview and record lity failed to ensure each nent program was integrated, onitored by the Qualified Professional (QMRP) for two (Clients #4 and #8) tesiding in				

ORM CMS-2567(02-89) Previous Versions Obsolete

		IAND HUMAN SERVICES B. MEDICAID SERVICES			FORM	: 12/04/2007 APPROVED
STATEMEN	TOF DEFICIENCIES DE CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	ULTIPLE CONSTRUCTION DING	(X3) DATE S COMPIL	
NaNes em e		09G12B			11/2	1/2007
ID!	ROVIDER OR SUPPLIER			Street Address, City, State, Zipic 431 53RD STREET, SE Washington, DC 20019	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	PREPI TAG		on should be le appropriate	(%) COMPLETION DATE
W 159	received effective tr	ito ensure that the staff aining on preparing Resident ance with her prescribed	W 1	(1) Reference nes		
W 189	received effective to reporting malfunction W436]	ed to ensure that the staff alining on monitoring and ining assistive devices. [See:	W 1	(2) Reference M W 436,	25 powie 18	
	The facility must prointled and continuing	wide each employee with y training that enables the n his or her duties effectively:				
}	Based on observation review, the facility facili	not met as evidented by: on, interview and record ided to ensure that each ded with initial and continuing I the employee to perform his i		This Standard met as evidence	will be ed by:	
	The find ings include	:				,
		to ensure that the staff were the "Incident Manageme nt"		(1) Reference re to W149		1-
- [2. The facility failed to effectively trained on accordance with each			(2) OMRP WILL propaded additional straining to e	4 10040- 11 - 1	ate
		to ensure staff were trained diately report client dignity below:		each clients of needs are m	duetary set.	
RM CMS-256	7(02-00) Previous Versions C	Displate Event ID: GWZA		 	continuation sheet P	age 15 of 21

PRINTED: 12/04/2007

		AND HUMAN SERVICES & MEDICAID SERVICES	-		FORM	: 12/04/2007 APPROVED 0938-0391
	TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDERSUPPLIER/CLIA IDENTIFICATION JUMBER:	(X2) MULT A. BUILDII	TPLE CONSTRUCTION	(X3) DATES COMPL	URVEY
ļ		09 G12 3	B, WING_		100	1/2007
NAME OF P	ROVIDER OR SUFFLIER	 		NEET ADDRESS, CITY, STATE, ZIP CODE	<u>_ 11</u>	112001
IDI		_		isi sord street, se Washington, DC 20019		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Tement of deficiencies "Must be preceded by full sc identifying information)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SH (EACH CORRECTIVE ACTION SH CROSS-REPERENCED TO THE APP DEFICIENCY)	OULD BE	O(5) CONFLETION DATE
W 331	Services, the Assis Services, and the Crecords on Novembracellty nurse, in an from picking at an in the client's hands whenches evening should be serviced there was no evide Client #1's hands where the cooks were removed 483,460(c) NURSIN The facility must proservices in accordance.	inector of Residential tent Director of Residential tent Director of Residential tent Director of Residential tent Director of Residential tent Part Part Part Part Part Part Part Par	W 189	(3) Reference nespon WISS. WISS. This Standard will met as evidenced	l be d by:	
	Based on observation review, the facility's ensure that each clicin accordance with the clients included in the finding includes. Review of the incide on November 20, 20 revealed the following buse and/or injuries involving Client #1: On September 9, 20 #1 was observed with On September 10, 2	inot met as evidented by: on, interview and retord nursing services falled to ent received nursing services heir needs, for one of the four is sample. (Clients #1) of reports and investigations of beginning at 2:01 PM g incident (allegations of s of unknown source) of, staff reported that Client heablister on her left wrist. onal (QMRP) documented an		Nume no longer is employed with agency. RN will continue munity and suppressing service and provide trained and feedback as	to evuse s uning	
		eldent report that revealed	1	needed to ensure	wation sheet F	

		AND HUMAN SERVICES & MEDICALD SERVICES				FORM	12/04/2007 APPROVED 0938-0391
TATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLERALIA IDENTIFICATION NUMBER:	(X2) N		PLE CONSTRUCTION IG	(X3) DATE S COMPLI	URVEY
· .	·	096459	is. wo	NG_		11/2	1/2007
name of P 101	ROVIDER OR SUPPLIER			4	reet aderess, city, state, zip code 31 63RD street, se Washington, dc 20019		İ
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEPCIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION	FREE FAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPRINCIPACY)	TION ULD BE OPRIATE	(XS) COMPLETION DATE
W 331	Client #1 had a sec An investigation was 11, 2007 to ascerta According to the invinjuries appeared to rubber bands place person that placed to on the client's wists On September 13, 2 notified of an allega #1. According to int Director of Resident staff member ellegand received the affirm wist as a result of the Director of Resident 2007 and further received that investigation was on the investigation was conditionable to the allegation was responsing to the place on Client #1's causing injury to he shower chair and what is the Derma bond. Client the Derma bond carremoved and re-operation to the formal bond. Client fine Derma bond carremoved and re-operation to the staff the time of the time of the staff the time of th	ond blister on her right wrist. Is conducted dated September in the cause of the Injuries. Restigation the source of the pestigation the source of the pestigation the source of the pestigation the source by source and don Client #1's hards but the the socks and rubber bands are mained unknown. 2007, the provider agency was also of abuse involving Client therefore, with the Assistant that Services and the QMRP, a at that Client #1 was abused or mentioned injuries to her the abuse. Interview with the fial Services on November 201 cord review revealed a second or ducted by the facility to on of abuse. Interview with dential Services and review of minary dated September 24, the facility's Licensell Practical ible for placing the socks and a client's hands that ed the injury. The Investigation wealed that the socks were hands to prevent her from a forehead. 2007, Client #1 tell from a as noted to receive a chead that was treated with the socks was a chead that was treated with the socks and the pick at using the adhesive to be	W	331	W331. continued Umpliance with H Standard.		
TOTAL CRIES	87/02-09) Previous Vansions	Obsolete Event ID: GWZM	4	Fac	 	uation sheet	Page 18 of 21

DEPA	RTMENT OF HEALTI	AND HUMAN SERVICES	•	•	PRINTE): 12/04/2007	
CENTE	ERS FOR MEDICARI	& MEDICAID SERVICES				APPROVED 0.0938-0391	
STATEMEN AND PLAN	nt of d eficiencies of correction	(X1) PROVIDERSUPPHERICLIA IDENTIFICATION NUMBER	l l	PC) MULTIPLE CONSTRUCTION A BUILDING		(X3) DATE SURVEY CORPLETED	
	.,	69G123	B. WIN	3			
"NAME OF	PROVIDER OR SUPPLIER	*****************		STREET ADDRESS, CITY, STATE, ZIP (21/2007	
IDI		· 		431 53RB STREET, SE WASHINGTON, DC 20019	JUDE .	•	
(X4) ID PREFIX TAG	CEACH DEFICIENCY	Tement of deficiencies Must be preceded by full SC IDENTIFYING INFORMATION)	ID PREFIX TAS	PROMDER'S PLAN OF C	n should ée Eappropriate	COMPLETION DATE	
W 331	Continued From pa	ge 18	W St	11			
	provided in accordanceds.	nce with the the client's					
W 436	483.470(g)(2) SPA	ZE AND EQUIPMENT	W 43	16 W 436			
·	and teach clients to choices about the u- hearing and other c- and other devices ig	nish, maintain in gaod repair, use and to make informed se of dentures, eyeblasses, ommunications aids, braces, entified by the		This Standard met as evide	wll be inced by	·	
	Based on observation verification, the facili maintenance of each	-		omer will follow to ensure that tech communications is in device is in working order	catori	12.3.07 organig	
W 460	device was inoperable review of the habilitar client had an objective communication device bedroom 3 of 5 trials button with hand over daily. At the time of the series of	IM revealed a ce for Client #4. The the staff and noted that the le. Further interview and lion records revealed the le to use a "low-tech of her while pressing the dealed when a seistance 1 time the survey, the facility falled communication dedice was epair. AND NUTRITION	W 460	W)460			
	Cach client must rece 17(02-99) Previous Versions Of						
AN CHICARO	r (estas) Literiora Adusious Ol	scolete Evant ID: GWZOC 1	: Fa	dify ID: 096123	ontinuation sheet Pr	*** 10 mf 71	

If continuation sheet Page 19 of 21.

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			FORM	APPROVED
STATEMEN	TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPILIER/CLIA IDENTIFICATION NUMBER	A BUILL	LTIPLE CONSTRUCTION DING	(X3) DATES	
		59G1 2 3	B. WING		4.00	14 man
NAME OF F	ROVIDER OR SUPPLIER		3	TREET ADDRESS, CITY, STATE, ZIA: 431 53RD STREET, SE WASHINGTON, DC 20019		<u>11/2007</u>
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION	PREFIX TAS	PROVIDER'S PLAN OF C (EACH CORRECTIVE AUTH CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE	(XS) COMPLETION DATE
W 460	Continued From page	a 19	W 45	DIMME O MALLED	and d	
	well-balanced diet in specially-prescribed	ncluding modified and diefs,		Wigo, will	<u>_</u>	
	Based on observation review, the facility far received their meals		·	This Standard be met as e by:	d will undersed	
·	2007 at approximate Client #8 was served The direct care staff feed the client, howe 6:15 PM, the direct of 6:15 PM, the	inner meal on November 20; ly 6:09 PW revealed that I colesiaw, beans, and beef. was observed to attempt to ver she refused to eat. At are staff was observed to e to rewarm Client #8's food	,	additional staff in nutrition me Camer/Home Mayor	training, magement, iger will	
	the texture of the clie However, at the time client's food appeare soup. The nurse was 183's mealtime protoc recommended texture 3:32 PM, the direct of attempt to offer to fee continued to refuse to nterview with the direct evesled that the staff lient's supplement (It is the staff member independent in the staff member in the s	act care staff at 6:35 PM f mixed three scoops of the peneprotein) into her food, licated that the added		conduct mealth and provide divec feedback for str needed to ensu compliance with standard. Medical/wersin will also mo	hon and off as ne ongoining he this	UN)
		ably the cause of the food's. Review of the Mealthne	<u>.</u> ,	meal preparation	m/feeding	

CENTE!	RS FOR MEDICAL FOR DEFICIENCIES OF CORRECTION	TH AND HUMAN SERVICES RE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1'	TIPLE CONSTRUCTION	OMB N	M APPROVE O. 0938-039 SURVEY LETED	
			A BUILDI	NG		CEIED	
		0¥6113	B. WING			11/21/2007	
ID	rovider or suppliei	R	1 4	rest address, City, State, 21 431 53RD STREET, SE WASHINGTON, DC 20019	P CODE		
(X4) ID PREFIX TAG	EACH DEFICIEN	TATEMENT OF DEFICIENCIES CYMUST BE PRECEDED BY FULL R LSC (DENTIFYING IMPORMATION)	ID PREFIX TAG	PROVIDERS PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	CS) CONFLETION DATE	
W 460	however, revealed to	page 20 mber 20, 2007 at 6:35 PM d that the client was receive two scoops of the aprotein) instead of three.	W 460	to ensue comp With each inc	pliance	1.8.08	
,	at approximately nutritional training review of the ager included training liprotocol. At the trailing tabled to pro-	records on November 21, 2007 1:30 PM revealed that staff hati 1:30		dietary needs		ongoine	
		-			. .		
	r(02-99) Previous Versions		-		_		

PRINTED: 12/04/2007 FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER GRO123		(CC) Multiple Construction A Building B. Wing		(X3) DATE SURVEY COMPLETED			
		099123			STATE, ZIP CODE	11/2	1/2007
IDI	ROVIDER OR SUPPLIER	,	431 53FD	d Street, Se Igion, DC 20019			
(X4) ID PREMX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SCIDENTIFYING INPORMA	FULL .	ID PREFIX TAG	FROVIDER'S FLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	COMPLETE DATE
000 1	INITIAL COMMENT	3	, ,	1 000			
LDAG	November 19, 2007 A random sample of from a residential pormental retardation a survey findings wenthe group home and interviews and a revunusual incident representation.		21, 2007; selected, nales with The ons in ding	1044	This Statute will be as evidenced by:	e met	
		/ICE / DINING ARE Tall be clean, wholes properly prepared.		1 (1 44	3502.3	se to	1.8.08
	Based on observation review, the GHMRP resident's received a	met as evidenced by on, staff interview and falled to ensure that meals in a form and red for one of eight of	direcond :		Reference respond rederal Deficier Report W1890 W460.	ind	
	The finding includes	 -	}	I	•		
	2007 at approximate Client #8 was served The direct care staff feed the client, howe 6:15 PM, the direct of	linner meal on Novel ely 6:09 PM revealed d coleslew, beans, a l was observed to att ever she refused to d care staff was obsent se to rewarm Clienti	that not beef. empt to eat. At red to				
	the texture of the cli- However, at the time client's food appeare	w with the nurse reve ent's food should be e of the observation, ed to be the consiste	pureed. the				
cally Repuls	ation Administration WWW MWW DIRECTOR'S OR PROVIDE	M Ervsuppijer represent	rative's sidk	UNTURE	My		(XB) DATE 12-14-07

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GWZX11

If continuation sheet 1 of 7

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12/05/2007 13:16 FAX 202 518 9685 12/04/2007 UN:10 FAX 2024425450

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDENSUPPLIERICLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN B. WING	FLE CONSTRUCTION 6	(X3) DATE SURVEY COMPLETED		
		096123				11/21/2007
NAME OF P	ROVIDER OR SUPPLIER		431 53RD	STREET, STON, DC 2	0019	
(X4) ID PREFIX TAG	SUMMARY STATEMENT (EACH DEFICIENCY MUST E REGULATORY OR LSG IDEN	E PRECEDED BY		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-RÉFERENCED TO THE APPR DEFICIENCY)	LD BE COMPLETE
1 044	Continued From page 'I soup. The nurse was obs #8's mealtime protocol an recommended texture of it At 6:32 PM, the direct can attempt to offer to feed Cli continued to refuse to eat. Interview with the direct can revealed that the staff months supplement (benefit the staff months supplement was probably soupy consistency. Review Protocol on November 20, however, revealed that the recommended to receive I supplement (beneprotein) Review of training records at approximately 1:30 PM nutritional training on June review of the agendanceve included training in each oprotocol. At the time of the facility failed to provide evice their meals in accidetary needs. 3510.5(f) STAFF TRAININ Each training program shall imited to, the following: (f) Specialty areas related residents to be served inclinated to, betavior management, recreation, total communication to protocols;	d verified that if the food was present #8 again, it was obsident #8 again, it was obsident #8 again, it was three scoop protein) Into he ad that the edde the cause of the was the cause of the was the cause of this was coops of the instead of this was coops of the aged that the trailient's meathing is survey, howeld the condance with the the condance with the the condance with the the GHMRP luding, but not is sexuality, nutries.	the ureed. erved to out she PM ps of the or food; and the food's me 21, 2007 staff had or ther alming eaver, the out's their mot be and the limited ition,	1229	1229 3510.(F) Reference response W189 Federal Def Report.	e to
esith Repub	This Statute is not met as	evidenced by:				

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ND PLAN C	OF DEFICIENCIES (X1) PROVIDER/SUPPLIES (DENTIFICATION NO DESCRIPTION NO DESCRIPTI	Maek:	A BUILDING EL WING RESS, CITY, 5 ETREET, SE	TATE ZIP CODE	OG) DATE SU COMPLET	/2007
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (EACH DEFICIENCY MUST BE PRECEDED BY REGULATORY OR LSC IDENTIFYING INFORM	ES FFULL	ID PREFIX TAG	PROVIDER'S PLAN OF GOT (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	LENOUID BY	COMPLETE DATE
1 229	Continued From page 2 Based on observation, interview, and review, the GHMRP failed to ensure at effectively trained on each resident's differ one of the eight residents (Resident residing in the facility.	Betary plan	1229	Also reference ne to W460 Federa	sponses al Defición	1.5.08
	The finding includes: Observation of the clinner meal on No 2007 at approximately 6:09 PM reveal Client #8 was served colesiaw, beans The direct care stati was observed to feed the client, however she refused to 6:15 PM, the direct care staff was obsask the facility's nurse to rewarm Client the rnicrowave. At 6:24 PM, interview with the nurse of the texture of the client's food should	led that land beef: attempt to: ceat. At served to ent #8's foot		report.		
i.	However, at the time of the observation client's food appeared to be the consistency. The nurse was observed to review #8's mealtime protocol and verified the recommended texture of her food was at 6:32 PM, the direct care staff was attempt to offer to feed Client #8 again continued to refuse to eat.	on, the stency of view Client in the sipurced, observed to in, but she			ı	
	Interview with the direct care staff at a revealed that the staff mixed three scient's supplement (beneprotein) into The staff member indicated that the supplement was probably the cause soupy consistency. Review of the Minarcol on November 20, 2007 at 6, however, revealed that the client was recommended to receive two scoops supplement (beneprotein) instead of Review of training records on November 20, 2007 at 6, however, revealed that the client was recommended to receive two scoops supplement (beneprotein) instead of	casps of the other food's editime: 35 PM 5 of the food's editime 136 PM 5 of the				

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STATEMEN	T OF DEFICIENCIES OF CORRECTION	(XI) PROMDER/SUPPLIE IDENTIFICATION NE	ERICLIA PUBER:	W	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	· * ***********************************	096123		B. WING _	<u> </u>	11/21/2007		
NAME OF P	ROVIDER OR SUPPLIER	096123 ,	STREET AD	MESS, CMY.	STATE, ZIP CODE			
IDI				D STREET, SE STON, DC 20019				
, , , ,		<u> </u>	ļ.,	· · · · ·	PROVIDER'S PLAN OF CORRECT	TION (X5)		
(X4) ID PREFEX TAG	(EACH DEFICIENC	Atement of Deficiencie Y must be preceded by LSC Identifying imporm	PPULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS REFERENCED TO THE APPR DEFICIENCY)	OFF COMPLETE		
I 229	Continued From pa	age 3		1 229				
	nutritional training of review of the again included training in protocol. At the tile facility failed to pro	:30 PM revealed that on June 30, 2006. If da revealed that the leach client's mealth me of the survey, howide evidence that dis in accordance with	Aurther Training me Wever, the Dent's	,	3579.5 Emerger 1374	ncies		
1 374	3519.5 EMERGEN	ICIES		1 374	1374	160		
	GHMRP shall pron guardism, his or he no guardian, or the sponsoring agency soon as possible.	ices have been secunptly notify the resider next of kin if the representative of the resident's sifellowed by written not later than forty-eight	ant's Sident has le Letus as Olice and		This Statute will met as evidences Reference responsive Federal Deficient Report W148, WI	49 ongoing		
,	Based on interview GHMRP failed to a services were securesident's status possible to the result of kin if the representative of the ywritten notice at forty-eight (48) hor	t met as evidenced by and record review, ensure that after medured, prompt notifical would be made as sident 's guardian, his ident had no guardian the sponsoring agent and documentation nours after the incident (Resident #7) included	the fical fion of the fion as s or her len, or the sy, followed a later than if for one of		W153, W154, W' W159 and W18	100		
ı	The findings include	de:		1				
	on November 20, a revealed that on A that while at the day	dent reports and inve 2007 beginning at 2: Jugust 22, 2007, staf ay program Client #7 a swollen right elbor	01 PM fireported 'Iwas					

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09G123	(X3) DATE SURVEY COMPLETED 11/21/2007	
NAME OF PROVIDER OR SUPPLIER 431 53RD \$TREET, SE		
IDI WASHIRETON, DC 20019		O/F)
(24) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION SHOULD BE PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY)	BE '	COMPLETE DATE
1374 Continued From page 4 #7 was taken to the emergency room and was subsequently diagnosed with a contustion of the elbow. Further review of the incident report revealed that the client's legal guardian was notified of the incident on September 14, 2007 (twenty-three days after the injury). Interview with the Qualified Menual Retardation Professional (QMRP) on November 20, 2007, at 12/106 PM revealed information regarding the facility's Incident management system. According to the QMRP, the guardian was to be notified Immediately of all allegations of shalecand injuries of unknown origin. At the timeof the survey, the facility falled to ensure Client #7's guardian was made-aware of the aforementioned incident in a timely manner. 1379 1379 1379 In addition to the reporting requirement in 3519.5, each GHMRP shall notify the Department of Health, Health Facilities Division of any other unusual incident or event which substantially interferes with a resident's health, waltare, living arrangement, well being or in any other way places the resident at risk. Such notification shall be made by telephone immediately and shall be followed up by written notification within twenty-four (24) hours or the hext work day. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure the Department of Health, Health Facilities Division was immediately, followed by written notification within 24 hours, notified on unusual incidentiating that		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION ON THE PLAN OF CORREC		(X2) MULTIPLE CONSTRUCTION A. BUILDING E. WING		(03) DATE SURVEY COMPLETED					
NAME OF SIGNATURE OF STATE (SE	0.96123			DRESS, CITY, STATE, ZIP CODE					
NAME OF PROVIDER OR SUPPLIER 101 WASHINGTON, DC 20019									
PRÉFIX (EACH DEFICIENCY MUI	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	TVE ACTION SHOULD BE SED TO THE APPROPRIATE					
at 2:01 IPM revealed the (allegations of abuse at source) were not reported. a. On August 22, 2007, #7 was observed to have right elbow at the day taken to the emergency subsequently diagnose elbow. Further review revealed that both the second control of the seco	ent reports and mber 20, 2007 beginning a following incidents ind/or injuries of unknown ted as required: staff reported that Chentive a swollen program. Client#7 was y room and was a dwith a contustion of the of the incident report administrator and the DOH) were notified of the	1379							
b. On Sisptember 9, 20 Client #1 was observed wrist. According to the administrator was notificated by the second of the Qualified Professional (QMRP) don the Incident report is a second blister on her noted that there was no notified of the aforement. 2. Additionally, interview medical record on Nove PM revealed that the cipodiatrist on February of the record revealed the discovered a "black disright great toe and Indication was not in									

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION DENTIFICATION NUMBER 994123		R/CLIA MBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING B. WING		(XS) DATE SURVEY COMPLETED			
NAME OF P	Rovider or Supplier		FADDRESS, CITY, STATE ZIP CODE SRED STREET, SE INGTION, DC 20019					
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			id PROVIDER'S PLAN OF C PRIEFIX (EACH CORRECTIVE ACTIVE TAG CROSS-REFERENCED TO THE DEFICIENCY			n#≓ .	(XI) COMPLETE DATE
) i) i) i sthiis shii	2007 at 7:40 PM, as with the nurse to as incident report regalincident. According was no occumented report. 3. Review of incide activities revealed sectivities revealed activities and aware of an incident nor any evident made activities with the Quart 12:06 PM revealed activity incident made the QMRP, the administrator and the dministrator and the dministrator and the	natologist. On Novem interview was conditionally the aforemental to the facility's nurse of evidence of an incitional terms of evidence of an incitional terms of evidence of an incitional askin tear on welling noted. During the mas neither any out for the aforemention that incident. Additional the incident. Additional terms of the incident of agency of abuse and gations of abuse and	ucted in coned of there ient lally 23, her right the ridence led latrator Rally, the tuntil 0, 2007, and the according to notified the	1 379				